# ADA Application

***The information obtained from this registration packet will be used by the Augusta Public Transit ADA Office to determine eligibility for Complimentary Paratransit Services and to ensure timely and accurate analysis of trip requests.***

**(Please Print Or Type All Information)**

**1**. Name _____

**2**. Street Address _____

**3**. Do you live within the city limits of Augusta? Yes _____ No _____

**4**. County _____ City _____ Zip Code _____

**5**. Nearest cross street/intersection _____

**6**. Phone Numbers:
(Home) _____ (Work) _____ (TDD) _____

**7**. Social Security Number _____

**8**. What is your disability? _____
_____

**9**. Is your disability temporary? YES _____ NO _____
If yes, expected duration? _____

**10.** Please check each mobility aid that you use:
Manual Wheelchair _____ Electric Wheelchair _____
Powered Scooter _____ Cane _____ Crutches _____
**Dimensions of Wheelchair/Scooter:**
_____ (Width in inches) _____ (Length in inches)
_____ (Estimated Weight in pounds when occupied)
Walker _____ Guide Dog _____ White Cane _____
Other _____

**11**. Will someone ride with you to your appointments? Yes _____ No _____

**12**. How far can you travel without the assistance of another person? _____ Feet

**13**. Can you climb three 12-inch steps without assistance?
Yes _____ No _____ Sometimes _____

**14**. Can you wait outside 10-15 minutes without the assistance of another person?
Yes _____ No _____ Sometimes _____

**15**. Please tell us anything else about your disability that you feel we need to know in order to help determine your eligibility.

_____
_____
_____

***** I hereby certify that the information given about me is correct and I understand that any intentionally false or misleading information is grounds for denial of Paratransit Services.**

**Signature of Applicant _____ Date _____**

***If this application was filled out by someone other than the applicant, that person must complete the following information:***

Name _____

Relationship to Applicant _____

Address _____ Apt/Suite _____

City _____ State _____ Zip Code _____

Phone Number (Include Area Code) _____

Signature _____ Date _____

******This Page To Be Filled Out By A Health Care Professional******

Name _____

Name of Facility or Agency
_____

Address _____

Room/Suite_____

City _____ State _____ Zip Code_____

Phone Number _____

Fax Number_____

Signature _____

Title_____

**1**. What is the applicant's disability?
_____
_____

**2**. Is this disability temporary?
Yes _____No_____

**3**. Does the applicant require an attendant while traveling?
Yes _____No_____

**4**. How far can the applicant travel without the assistance of another person?
_____Feet

**5.** Can the applicant climb three 12 inch steps without assistance?
Yes _____ No _____ Sometimes _____

**6**. Can the applicant wait outside for 10-15 minutes without the assistance of another person?
Yes _____ No _____ Sometimes _____

**7**. How does the disability affect the applicant's mobility?
_____

**8**. Does the disability prevent the applicant from using current bus system?
Yes _____ No____